



**FINAL ASSESSMENT REPORT:**

**USAID/PHILIPPINES SUPPORT TO  
LOCAL GOVERNMENTS FOR FAMILY PLANNING AND HEALTH**

**April 20, 2002**

## **Glossary of Abbreviations and Acronyms**

BHW	Barangay Health Worker
BLHD	Bureau of Local Health Development
CA	Cooperating Agency
CBMIS	Community Based Monitoring Information System
CHD	Center for Health Development
CHO	City Health Office/Officer
DMPA	Depo-Medroxy Progesterone Acetate
DOH	Department of Health
DOTS	Directly Observed Treatment Short Course
CPR	Contraceptive Prevalence Rate
EPI	Expanded Program of Immunization
FHSIS	Field Health Service Information System
FIC	Fully Immunized Child
FP	Family Planning
FPOP	Family Planning Organization of Philippines
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IEC	Information, Education, Communication
IRA	Internal Revenue Allotment
IUCD	Intrauterine Contraceptive Device
KII	Key Informant Interview
LCE	Local Chief Executive
LGU	Local Government Unit
LPP	Local Government Unit Performance Program
MCH	Maternal Child Health
MGP	Matching Grant Program
MHO	Municipal Health Officer
MOA	Memorandum of Agreement
MOOE	Maintenance and Other Operating Expenditures
MSH	Management Sciences for Health
NGO	Non-Government Organization
OIDCI	Orient Integrated Development Company Inc.
PMTAT	Project Management Technical Assistance Team
PMU	Project Management Unit
PopCom	Population Commission
RFA	Rapid Field Assessment
RHU	Rural Health Unit

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## **Executive Summary**

This study used a rapid field appraisal methodology conducted in 24 LGUs – 19 LGUs participating in MGP and five non-participating LGUs – from the island areas of Luzon, Visayas, and Mindanao. Three approaches were used: (1) key informant interviews with 387 respondents representing local government officials, LGU health service providers, family planning clients, non-users of contraceptives, and representatives from the private for profit sector, the private not for profit sector, local influential and religious leaders, and regional Centers for Health Development; (2) structured group discussions with respondents from each of the 24 LGUs; and (3) a desk review of background documents.

Since 1999, MGP has provided grants to 183 cities and municipalities from a line item in the DOH budget for “assistance to LGUs.” This line item has declined from P90 million in 2000 to P78 million in 2002. The DOH grant is accompanied by a 25% counterpart match from the LGUs. In 2001, DOH grants to cities and municipalities ranged from P25,000 to P500,000 per LGU. The median grant size is P250,000 in that year. The ratio of the MGP grant to health MOOE varies from 2.4% to 74.0% but on average is equal to 7.8%. Given the unit cost of family planning and MCH services exclusive of commodities, the average MGP grant is estimated to be sufficient to serve 20%-30% of households in a medium-sized LGU.

The assessment identified strengths in the MGP program design and implementation strategies that have contributed toward improved family planning delivery at the LGU level. In LGUs where MGP was implemented, family planning and family health were viewed as priority programs in the LGUs, and most have designated staff responsible exclusively for family planning. Innovative strategies were used to improve availability and expand access to family planning. The CBMIS is a valuable tool in the identification and referral of clients in need of family planning, immunization and Vitamin A supplementation. LGUs enrolled in the program were successful at achieving Sentrong Sigla status and enrolling in the PhilHealth Indigents Program. Technical assistance capacity has been established in regional CHDs, and the continuing budget appropriation for “assistance to LGUs” in the DOH budget represents an additional dedicated source of funding for family planning in LGUs, both of which contribute to the program’s sustainability.

impediments to better family planning services and quality of care. Opportunities for linkages with partners in the private sector were not optimized. It can be concluded that MGP has had an impact in those barangay where the CBMIS is being implemented. Since the CBMIS is being implemented in less than 30-40% of barangay due to limitation of funds, the aggregate impact of the MGP in the 183 LGUs covered is minimal.

Important lessons learned emerged from the assessment. MGP was most successful where commitment to family planning was highest and where the LCEs understood the link between population growth and economic development. To achieve demonstrable improvements in family planning and health at the LGU level, more resources are needed, both from the LGU and from “other sources.” Unless structured properly, the MGP grants can displace other LGU funds that otherwise would have been allocated to health. Integrating family planning services with other MCH care under the rubric of family health has enabled the LGU health system to address missed opportunities, and will be more politically acceptable to them.

There is a dearth of IEC and advocacy at the local level, and one-to-one counseling, as currently happening, needs to be strengthened. Barangay Health Workers (BHW) play a critical role in the program, as long as they are deployed in BHW-to-household ratios that do not exceed 1:50. The introduction of the CBMIS contributes significantly to program success; however, it has not been demonstrated whether it can be used effectively on a wider scale. Linkages with the private sector are weak and seldom used by LGUs to segment their clients. The family planning program is totally female oriented. More males need to be actively engaged as positive role models and advocates for family planning, and demand needs to be created for contraception among men.

In three years, MGP has been able to reach only 183 LGUs, with just 30% of barangay covered in these. Given that there are nearly 1,600 LGUs in the Philippines and the MGP is active in 183, perhaps the most important lesson learned after three years of implementing MGP is that there is a need to reconstitute the MGP, to achieve national impact on contraceptive prevalence.

Data from this assessment unearthed programmatic issues that will effect future program directions. LGUs zealously guard the autonomy granted them under the Local Government Code. They are likely to vigorously resist prescriptive

future, expanded if feasible, and transformed into more flexible disbursement arrangements that do not displace LGU resources. Collaboration with NGOs, commercial providers, other USAID projects, and other government agencies can be enhanced. In LGUs where HIV/AIDS programs are being implemented, family planning and TB control can be integrated at marginal cost.

The essential role played by the mayors was one of the most important program issues to emerge from this assessment. Mayors are critical to the support that family planning activities receive at the LGU level. If a mayor comes to understand that the family planning activities are a political plus and the program's success will make the mayor look good to his/her constituents and enhance the chances of reelection, then the family planning program at the LGU will move forward quickly.

## **INTRODUCTION**

The Strategic Objective for USAID's Population and Health Program in the Philippines is: "Desired family size and improved family health sustainably achieved." Four Intermediate Results Packages have been designed in order to achieve the strategic objective:

- Local Government Unit (LGU) provision and management of FP/MCH/TB/HIV/AIDS services strengthened.
- Provision of quality services by private and commercial providers expanded
- Greater social acceptance of family planning achieved
- Policy environment and financing for provision of services improved

With a view toward developing a program design that will support the first Intermediate Results Package for the period 2002 to 2006, USAID/Philippines commissioned a team to (1) conduct an assessment utilizing rapid field appraisal approaches of the current LGU project; and, (2) prepare a design document for new support to LGUs for the provision of family planning services.

### **The Rapid Field Assessment (RFA) methodology used three approaches:**

1. Key Informant Interviews (KIIs) from 24 LGUs distributed over three island groupings were conducted with local government officials, LGU health service providers, family planning clients, non-users of contraceptives, and representatives from the private for profit sector, the private not for profit sector, local influential and religious leaders.
2. Structured Group Discussions with selected interviewees from each of the 24 LGUs.
3. Desk Review of documents that provided background on the population and health sector in the Philippines in general, and USAID assistance to LGUs in particular.

### **This report is presented as follows:**

This section focuses on the assessment of USAID's assistance to LGUs. with

## **I. ASSESSMENT OF USAID PHILIPPINES ASSISTANCE TO LGUs THROUGH THE MATCHING GRANT PROGRAM (MGP)**

### **1. BACKGROUND AND DESCRIPTION OF MGP**

In order to address the needs of the devolved Philippine Health Care System, the Local Government Unit Performance Program (LPP) was launched in 1994. It was designed to improve the health of mothers and children through increased utilization of family planning (FP), maternal and child health (MCH) and nutrition services. The mid-term assessment of the LPP project conducted in 1998 posed several recommendations to enhance its impact and improve program performance. In response to these recommendations, the LPP was modified by adding two components: the Top Performers Program, and the Matching Grants Program (MGP). Base grants for 85 provinces and cities that had already started were continued. LGUs that exceeded the minimum coverage standards on outcome measures were given additional funding under the Top Performance Program. The third component, the MGP, was introduced to respond to the limitations of the base grant approach by focusing assistance directly for municipalities and requiring a counterpart funding from the participating LGUs.

The MGP was launched in February 1999 by the Department of Health with funding support provided by USAID and technical assistance from Management Sciences for Health (MSH).

A Project Management Technical Assistance Team (PMTAT) from MSH was assembled in Manila to support implementation of MGP. Regional technical assistance teams (RTAT) were created in the CHDs in each region to train LGUs in family planning and reproductive health using competency based training strategies; to make performance based grants; and to provide the following technical assistance package to the LGUs:

- CBMIS (Community-Based Management Information System)
- Health Facility Assessment leading to Sentrong Sigla Certification
- Family Planning training packages
- Disease Surveillance (optional module in 5 LGUs only)



In 2001, DOH grants to cities and municipalities under the MGP vary from P25, 000 to P500,000 per LGU. The median grant size is P250, 000 in that year. Given the unit cost of family planning and MCH services exclusive of commodities, the average MGP grant is estimated to be sufficient to serve 20%-30% of households in a medium-sized LGU.

The size of the grant is limited by the total amount of funding that is made available for “assistance to LGUs” in the DOH budget, the target number of LGUs and the prescribed cost sharing formula with LGUs. The allocation for the MGP in the DOH budget declined from P90 million in 2000 to P78 million in 2002. A comparison of the MGP grant with LGU spending on maintenance and other operating items in the health sector highlights the “smallness” of the MGP grant (Table 5)<sup>1</sup>. The ratio of the MGP grant to health MOOE varies from 2.4% to 74.0% but on average is equal to 7.8%.

MGP appears to have limited success in leveraging LGU spending on health. For instance, only 11 out of the 20 LGU included in the RFA posted increases in their real per capita health spending in 1999. Thus, the MGP appears to have displaced funds that would have been allocated to the health sector (Table 6).

Most LGUs contribute 25% of the total grant. Data from MSH indicates that over a quarter of LGUs put up more than 25% of the DOH grant (Table 6). For instance, Malaybalay registered the highest counterpart, contributing three times the grant amount. Key informants report that LGUs actually put more funds in the MGP than was required in the grant agreement. On the other hand, a small number of the LGUs had counterparts that are lower than 25% of the grant amount. This suggests that the grant design should also take into account the ability of poorer LGUs to provide counterpart funding support.

Table 4. MGP Grant and LGU Health Expenditures in Selected Sites, 2000

LOCATION		MGP Grant	Total Health Expenditures				Ratio of MGP Grant to Health MOOE (%)
			PS	MOOE	CO	Total	
<b>GOOD</b>		<b>3,700,000.00</b>	<b>111,681,410.87</b>	<b>43,191,547.63</b>	<b>6,647,888.68</b>	<b>161,520,847.18</b>	<b>8.6</b>
<b>LUZON</b>	Ilagan City, Isabela		10,029,317.69	3,023,254.52	213,088.50	13,265,660.71	0.0
	Daraga, Albay	300,000	7,633,689.47	2,819,619.40	-	10,453,308.87	10.6
	Naga City, Camarines Sur	300,000	18,177,244.94	7,248,123.61	7,558.50	25,432,927.05	4.1
<b>VISAYAS</b>	Bayawan, Negros Oriental	1,500,000	7,480,591.94	2,027,116.89	1,006,609.59	10,514,318.42	74.0
	Bago City, Negros Occidental	300,000	33,316,274.53	8,026,422.35	1,064,677.14	42,407,374.02	3.7
	Ormoc City, Leyte	400,000	12,442,578.50	9,984,971.50	2,373,542.77	24,801,092.77	4.0
<b>MINDANAO</b>	Bislig City, Surigao del Sur	400,000	8,308,897.46	1,744,549.35	-	10,053,446.81	22.9
	Kidapawan City, North Cotabato	250,000	5,870,094.23	809,177.00	825,550.00	7,504,821.23	30.9
	Tagum City, Davao del Norte	250,000	8,422,722.11	7,508,313.01	1,156,862.18	17,087,897.30	3.3
<b>POOR</b>		<b>2,900,000.00</b>	<b>100,428,051.82</b>	<b>47,408,651.32</b>	<b>4,878,046.21</b>	<b>152,714,749.35</b>	<b>7.1</b>
<b>LUZON</b>	Dasmarinas, Cavite	500,000	5,629,223.45	9,078,271.69	325,050.00	15,032,545.14	5.5
	Concepcion, Tarlac	500,000	4,995,178.86	3,296,041.65	-	8,291,220.51	15.2
	Malasaqui, Pangasinan	500,000	3,914,420.38	1,543,358.67	-	5,457,779.05	32.4
	Legaspi City	400,000	14,613,690.93	3,627,736.55	-	18,241,427.48	11.0
<b>VISAYAS</b>	Silay City, Negros Occidental	300,000	9,208,013.08	12,459,362.59	-	21,667,375.67	2.4
	Talisay City, Cebu	150,000	10,824,045.40	5,635,339.72	4,142,828.21	20,602,213.33	2.7
	Tacloban City, Leyte	N/A	11,742,136.20	3,303,266.21	167,618.00	15,213,020.41	-
	Calbayog City, Western Samar	N/A	21,603,740.85	2,017,531.50	-	23,621,272.35	-
<b>MINDANAO</b>	Magsaysay, Davao del Sur	250,000	2,524,922.96	1,198,109.08	-	3,723,032.04	20.9
	Pagadian City, Zamboanga del Sur	300,000	12,991,971.29	4,267,371.50	172,550.00	17,431,892.79	7.0
	Compostela, Compostela Valley	N/A	2,380,708.42	982,262.16	70,000.00	3,432,970.58	-
<b>MGP</b>		<b>6,600,000.00</b>	<b>212,109,462.69</b>	<b>90,600,198.95</b>	<b>11,525,934.89</b>	<b>314,235,596.53</b>	<b>7.3</b>
<b>NON-MGP</b>			<b>61,808,753.03</b>	<b>15,922,511.73</b>	<b>1,609,270.92</b>	<b>79,340,535.68</b>	
<b>LUZON</b>	Calabanga, Camarines Sur		4,490,309.14	1,290,000.00	-	5,780,309.14	
	Marikina, Matro Manila		28,707,247.00	9,104,271.73	1,609,270.92	39,420,789.65	
<b>VISAYAS</b>	Mandaue City, Cebu		8,982,808.83	3,590,871.19	-	12,573,680.02	
<b>MINDANAO</b>	Butuan City, Agusan del Norte		19,628,388.06	1,937,368.81	-	21,565,756.87	

Table 5. Per Capita Health Expenditures of Selected MGP and Non-MGP LGUs, 1998-2000

LOCATION		in 1998 prices				in 1998 prices				in 1998 prices			
		Per Capita Health Expenditures				Per Capita Health Expenditures				Per Capita Health Expenditures			
		PS	MOOE	CO	Total	PS	MOOE	CO	Total	PS	MOOE	CO	Total
		1998	1998	1998	1998	1999	1999	1999	1999	2000	2000	2000	2000
<b>GOOD</b>		<b>87.44</b>	<b>26.85</b>	<b>0.77</b>	<b>115.06</b>	<b>92.07</b>	<b>40.40</b>	<b>5.68</b>	<b>138.15</b>	<b>85.33</b>	<b>33.00</b>	<b>5.08</b>	<b>123.41</b>
<b>LUZON</b>	Ilagan City, Isabela	71.70	9.15	-	80.85	63.11	20.76	-	83.87	72.40	21.82	1.54	95.76
	Daraga, Albay	69.29	21.31	1.37	91.97	63.25	22.61	0.45	86.31	65.49	24.19	-	89.69
	Naga City, Camarines Sur	117.42	44.29	-	161.70	106.32	41.91	0.67	148.90	114.39	45.61	0.05	160.05
<b>VISAYAS</b>	Bayawan, Negros Oriental	67.86	14.75	0.20	82.81	116.98	25.00	8.84	150.82	63.92	17.32	8.60	89.85
	Bago City, Negros Occidental	206.30	48.32	1.83	256.45	201.19	43.21	0.51	244.91	203.97	49.14	6.52	259.63
	Ormoc City, Leyte	74.84	60.17	2.94	137.94	68.09	54.23	27.02	149.34	69.97	56.15	13.35	139.46
<b>MINDANAO</b>	Bislig City, Surigao del Sur	75.50	14.78	-	90.28	71.23	16.81	-	88.04	74.00	15.54	-	89.54
	Kidapawan City, North Cotabato	45.85	2.12	-	47.97	72.11	13.96	0.84	86.91	50.19	6.92	7.06	64.17
	Tagum City, Davao del Norte	41.29	9.36	-	50.65	57.83	84.97	6.57	149.37	40.61	36.20	5.58	82.38
<b>POOR</b>		<b>12.78</b>	<b>2.94</b>	<b>0.39</b>	<b>16.11</b>	<b>66.24</b>	<b>22.29</b>	<b>1.28</b>	<b>89.81</b>	<b>56.96</b>	<b>26.89</b>	<b>2.77</b>	<b>86.62</b>
<b>LUZON</b>	Dasmariñas, Cavite	1.00	0.28	0.00	1.28	23.89	4.91	0.41	29.20	12.73	20.53	0.74	34.00
	Concepcion, Tarlac	36.44	12.53	-	48.97	34.93	15.11	0.07	50.10	37.55	24.78	-	62.33
	Malasaqui, Pangasinan	35.72	14.07	-	49.80	31.44	6.47	0.25	38.17	29.96	11.81	-	41.77
	Legaspi City	83.55	19.77	-	103.32	87.83	28.12	-	115.95	80.66	20.02	-	100.68
<b>VISAYAS</b>	Silay City, Negros Occidental	119.04	26.62	20.06	165.73	67.87	85.15	-	153.01	74.70	101.07	-	175.77
	Talisay City, Cebu	65.07	12.18	0.74	77.99	72.68	33.77	18.84	125.29	118.33	61.61	45.29	225.23
	Tacloban City, Leyte	121.75	35.16	3.52	160.43	109.51	28.36	-	137.87	57.04	16.05	0.81	73.90
	Calbayog City, Western Samar	141.57	8.48	0.50	150.55	129.49	8.96	1.32	139.77	127.07	11.87	-	138.94
<b>MINDANAO</b>	Magsaysay, Davao del Sur	51.70	15.39	-	67.10	50.30	24.59	0.22	75.11	50.82	24.11	-	74.93
	Pagadian City, Zamboanga del Sur	102.53	26.04	0.92	129.48	99.78	31.68	0.27	131.73	78.92	25.92	1.05	105.90
	Compostela, Compostela Valley	35.76	15.19	1.06	52.01	34.91	15.09	-	49.99	33.44	13.80	0.98	48.22
<b>MGP</b>		<b>21.56</b>	<b>5.75</b>	<b>0.44</b>	<b>27.75</b>	<b>77.52</b>	<b>30.19</b>	<b>3.20</b>	<b>110.91</b>	<b>69.05</b>	<b>29.49</b>	<b>3.75</b>	<b>102.29</b>
<b>NON-MGP</b>		<b>88.46</b>	<b>21.28</b>	<b>29.68</b>	<b>139.42</b>	<b>81.02</b>	<b>27.59</b>	<b>15.97</b>	<b>124.59</b>	<b>54.27</b>	<b>13.98</b>	<b>1.41</b>	<b>69.66</b>
<b>LUZON</b>	Calabanga, Camarines Sur	80.26	9.38	-	89.65	73.62	10.27	-	83.89	57.67	16.57	-	74.24
	Marikina, Metro Manila	67.80	5.56	0.96	74.33	63.72	20.66	1.47	85.85	63.62	20.18	3.57	87.37
<b>VISAYAS</b>	Mandaue City, Cebu	41.14	57.70	0.10	98.94	35.15	57.35	0.09	92.59	29.77	11.90	-	41.68
<b>MINDANAO</b>	Butuan City, Agusan del Norte	162.93	14.51	105.31	282.76	151.06	14.19	56.03	221.28	63.70	6.29	-	69.98



**Table 6. MGP Grant and LGU Counterpart: 2001**

Region	Province	LGU	MGP Grant	LGU Counterpart	LGU Counterpart- MGP Grant Ratio (%)
1	Ilocos Norte Pangasinan	Laoag City	500,000	244,000	48.8
		Asingan	100,000	150,000	150.0
		Bayambang	500,000	125,000	25.0
		Malasiqui	500,000	125,000	25.0
2	Isabela	Cauayan	500,000	125,000	25.0
		Isabela	500,000	150,000	30.0
3	Bulacan Zambales Tarlac Pampanga	San Miguel	500,000	125,000	25.0
		Iba	500,000	125,000	25.0
		Concepcion	500,000	284,396	56.9
		Lubao	500,000	125,000	25.0
4	Rizal Laguna Palawan Cavite	Taytay	500,000	325,000	65.0
		San Pablo	500,000	125,000	25.0
		Puerto Princesa	500,000	125,000	25.0
		Dasmariñas	500,000	135,000	27.0
5	Camarines Sur Albay	Naga	300,000	350,000	116.7
		Daraga	300,000	75,000	25.0
		Tabaco	300,000	75,000	25.0
		Legaspi	400,000	100,000	25.0
6	Negros Occidental	Bago City	300,000	175,000	58.3
		Kabankalan	300,000	75,000	25.0
		Silay	300,000	300,000	100.0
7	Negros Oriental Cebu	Bayawan District	1,500,000	980,000	65.3
		Bogo	300,000	75,000	25.0
		Talisay	150,000	37,500	25.0
		Lapu-lapu	500,000	125,000	25.0
8	Leyte South Leyte	Ormoc City	400,000	100,000	25.0
		San Ricardo	500,000	100,000	20.0
		Padre Burgos	500,000	125,000	25.0
		Tacloban City			
	Western Samar	Calbayog City			
9	Zamboanga del Norte	Dipolog City	300,000	65,000	21.7
	Zamboanga del Sur	Pagadian City	300,000	62,500	20.8
10	Bukidnon Misamis Occidental	Malaybalay	500,000	1,500,000	300.0
		Ozamis City	500,000	125,000	25.0
11	Davao del Norte	Tagum	250,000	62,500	25.0

## **1.2 COVERAGE**

The number of barangay covered by MGP is tied to the size of the DOH grant to the LGUs. The coverage target is the 30-40% of the barangay in each municipality that are considered either low performers, inaccessible, poor, or in greatest need. The number of households (and ultimately barangay) that can be covered in each municipality is determined by taking the amount of the DOH grant and dividing by P70, the estimated average cost of providing family planning, immunization, and Vitamin A for one family for one year. Based on this figure, the LGU decides the number of barangay that can be covered and which barangay to cover; and implements the CBMIS in these barangay. .

In most instances the DOH grant combined with the LGU counterpart is not sufficient to reach the target of 30-40% of barangay. Consequently, MGP is only being implemented in a small percentage of barangay in each LGU. The coverage data for those barangay, however, is quite good. FIC coverage ranges from 80-95%. TT2+ for pregnant women is above 70%. Vitamin A coverage is above 85%. CPR for modern contraceptive methods is above 40%<sup>2</sup>.

## **2. METHODOLOGY FOR RAPID FIELD APPRAISAL (RFA)**

The RFA methodology produces qualitative data that is tabulated to determine trends and commonly held beliefs. Extensive efforts were made to quantify KII responses. Each of the 24 structured group discussions was summarized to highlight consensus by the participants.

### **Specific Methodologies for the Rapid Field Appraisal**

The methodology used for the diagnostic component of this assignment consisted of interviews with key informants, structured group discussions, and a desk review of relevant project documents. OIDCI was contracted to undertake fieldwork, and with the assistance of the Design Team developed the study protocols, pre-tested questionnaires, facilitated the group discussions and conducted the key informant interviews. Management Sciences for Health staff assisted in choosing the 24 LGUs. Briefing materials were provided to the RFA Survey Team to ensure uniform interpretation of the questions and data requirements.

### Sample Size

The sample size covered by the RFA included 24 LGUs categorized as good performers, low performers<sup>3</sup> and non-participating LGU. The designation as a “low performer” was a subjective determination by the MSH technical assistance team.

**Table 1. Geographic Distribution of the Sample LGUs**

<b>LOCATION</b>	<b>GOOD</b>	<b>LOW</b>	<b>NON-MGP</b>
<b>LUZON</b>	Ilagan City, Isabela  Daraga, Albay  Naga City, Camarines Sur	Dasmarinas, Cavite  Concepcion, Tarlac  Malasiqui, Pangasinan  Legazpi City	Calabanga, Camarines Sur Marikina, Metro Manila
<b>Sub-total</b>	3	4	2
<b>VISAYAS</b>	Bayawan, Negros Oriental Bago City, Negros Occidental Ormoc City, Leyte	Silay City, Negros Occidental Talisay City, Cebu  Tacloban City, Leyte Calbayog City, Western Samar	Mandaue City, Cebu
<b>Sub-total</b>	3	4	1
<b>MINDANAO</b>	Bislig City, Surigao del Sur Kidapawan City, North Cotabato Tagum City, Davao del Norte	Pagadian City, Zamboanga del Sur Compostela, Comval	Magsaysay, Davao del Sur Butuan City, Agusan del Norte
<b>Sub-total</b>	3	2	2
<b>TOTAL</b>	9	10	5

### 2.1 Review of Relevant Documents

A list of documents was provided by USAID to the design team. In addition, other project documents relevant to the Philippine population program and the MGP were added to the list. The review of these documents helped to identify key issues related to the MGP and these were used as inputs in the development of the study protocols. A list of these materials is provided in Attachment 1.

Structured Group Discussions (SGDs) were conducted in the 20 LGUs where the MGP was implemented. This data collection method is very similar to a focus group discussion in which the collective responses from a pre-selected group are obtained and consensus is used as an indicator of central tendency and dissension is an indicator of variability. In the structured group discussions the participants are not necessarily homogeneous but are selected on the basis of being stakeholders in the MGP and the delivery of family planning services or as clients. The typical composition of SGD per LGU would include the following participants:

- MHO/CHO Coordinator
- Family Planning Coordinator
- Local Population Officer
- Municipal/City Planning and Development Coordinator
- Midwives from the Rural Health Units and Barangay Health Stations
- NGO representative in the area
- Barangay Health Workers

The ~~OIDCI~~ facilitator led the SGD while a second staff member documented the proceedings using uniform formats/templates for uniformity of information. Generally, there were no observers during the SGD except in cases where some members of the Design Team participated as observers. The SGD was done on-site and held at the facility of the municipal or city health office and lasted two hours on the average. A facilitator and one research associate handled the discussions.

The total number of participants for the SGDs was 347: Luzon (100), Visayas (158) and Mindanao (88). Guide questions used for the SGDs are found in Attachment 2.

### **2.3 Key Informant Interview**

The key informant approach uses interviews with key informants to obtain their views on MGP implementation. This approach is most effectively used to describe trends and make assessments of the MGP, taking into consideration different perspectives represented by the different respondents.



**Table 2. Profile of KII Respondents**

<b>Respondent</b>	<b>Luzon Number Reporting</b>	<b>Visayas Number Reporting</b>	<b>Mindanao Number Reporting</b>	<b>Total Number Reporting</b>
<i>CHD Director/LPP</i>	5	3	2	10
<i>Municipal/City Health Officer</i>	10	9	7	26
<i>Public Health Nurse</i>	11	11	8	30
<i>Rural Health Midwife</i>	11	9	8	28
<i>Mayor/City Admin</i>	5	5	6	16
<i>V. Mayor/SB Health</i>	5	8	7	20
<i>City Planning</i>	7	6	6	19
<i>Population Staff</i>	13	6	6	25
<i>BHW</i>	16	16	14	46
<i>Barangay Captain</i>	8	10	7	25
<i>Private Sector</i>	8	8	8	24
<i>User/Non user</i>	40	40	35	115
<i>Others</i>	3			3
<b>TOTAL</b>	<b>142</b>	<b>131</b>	<b>114</b>	<b>387</b>

### **3. LIMITATIONS OF THE RFA**

The RFA was conducted under acute time constraints. Because the study period coincided with the Holy Week holidays from March 28-31, the entire study – preparing and field testing questionnaires, training and standardizing interviewers, and collecting data – had to be completed in two weeks. Initial compilation of the results and interpretations were performed in the three days before Easter weekend. Given these considerations, the design team had to modify the group discussions, by adopting flexible criteria for inclusion of participants in the discussion groups, thus making the groupings less homogeneous. The facilitator made sure, however, that activities were guided carefully in order to obtain maximum participation from all members during the group discussions.

It must be pointed out that selection of participants in the study was not meant to constitute a representative sample of the population. The major purpose of the

## **4. FINDINGS**

The findings which are summarized here have been synthesized from detailed data that has been compiled and tabulated from the key informant interviews and structured group discussions.

### **4.1 KEY SUCCESSES - STRENGTHS**

The assessment identified strengths in the MGP program design and implementation strategies that have contributed toward improved family planning delivery at the LGU level. The successful elements of the MGP are summarized below:

- Family planning and family health were viewed as priority programs in the LGUs because of the visibility bestowed by MGP and the program's accompanying grant resources. In non-MGP areas, family planning and child health were never mentioned as priority programs.
- In over 80% of the LGUs a point person for family planning activities has been appointed to oversee the implementation of MGP activities.
- In all 20 LGUs with the MGP there was clear evidence that the public health nurse and other staff at the RHU had drawn up innovative strategies to expand the delivery of family planning. We found many examples where family planning services were integrated into a variety of maternal and child health services and included in community events. We discovered cases where BHWs were now re-supplying low dose pills to clients and barangay midwives had been trained and equipped to insert IUCDs.
- The CBMIS is a valuable tool in the identification and referral of clients in need of family planning, immunization and vitamin A supplementation. Several LGUs instituted the CBMIS in all their barangay on their own initiative. This was accomplished with very little cost and utilized the trained BHW from the small number of barangay selected under the MGP for installing the CBMIS.

- The MGP greatly facilitated the LGUs identifying and enrolling indigent persons in PhilHealth. At present, 55% of LGUs participating in MGP have enrolled in PhilHealth. In addition the MGP targeted LGU health resources towards the poorest barangay with the greatest need for services.
- MGP has established strong linkages with regional CHDs. Regional Technical Assistance Teams (RTAT) have been established in 16 regions that can provide technical assistance and training required under MGP to the LGUs. Sufficient technical capacity has been developed in 10 of 16 regions to provide requisite technical assistance to LGUs independent of MSH.
- A DOH budget line item for “assistance to LGUs” was created within the regional CHD budgets, from which grants are provided to LGUs for family planning and family health. This line item is a continuing appropriation that will continue beyond MGP. These funds constitute an additional dedicated source of funding for family planning and family health services in LGUs. This budget line item is a conduit for continued central funding to LGUs for family planning that can be maintained and possibly increased in the future.
- LGUs have been successful in improving quality of care by attaining the Sentrong Sigla status. Sixty percent of LGUs participating in MGP have attained Sentrong Sigla status, which in some cases was accompanied by a P 1 million award.

#### **4.2 WEAKNESSES**

Conversely, the assessment identified weaknesses in program design that detracted from MGP’s potential impact. These are summarized below:

- The grant is provided as project support to LGUs from the regional CHDs. A project plan must be developed, an MOA must be signed, and then funds are advanced, liquidated, and replenished. This process was administratively cumbersome when done on the scale of 183 LGUs. As a result, fund utilization was slow, rates of expenditure were low, and the

- MGP only reached 20-30% of the Barangay in an LGU because of fund limitations. The size of total grant funds available for MGP decreased in real and nominal terms from 2001 to 2002 as MGP expanded to larger numbers of LGUs, further limiting potential impact.
- It was not possible to ascertain definitively whether the grant to LGUs resulted in a net increase in LGU expenditures on health. In fact, there was some evidence that the grant displaced funds that would otherwise have been allocated to health services.
- MGP was not well marketed and communicated to the LGUs. Communication was primarily linear through health channels, from the CHDs to the MHO/CHOs. Many LCEs were not aware that MGP was being implemented in their LGUs. It is only one of many programs vying for their attention and because of its size, was usually referred directly to the MHO/CHOs for action. This was a missed opportunity to gain political and programmatic support for family planning from the LCEs.
- MGP sets annual service targets but there is no linkage between performance and the grant. Funds may be allocated in subsequent years regardless of whether performance benchmarks were satisfactorily met.
- There is no satisfactory methodology in place that can track performance of the annual service targets on a regular basis. Without such a tool, it is not possible to monitor progress toward achievement of targets.
- All LGUs in MGP areas cited deficiencies with IEC, interpersonal counseling, and local advocacy as impediments to better family planning services and quality of care. These were not adequately addressed in the MGP design. Because it was dealing almost exclusively with the city/municipal health office of the participating LGU, MGP was not able to harness the resources and capability that are available in the population offices that are present in city governments. Given the structure and organization prevalent in most LGUs, the local health office is tasked with the delivery of family planning services while the local population office is tasked with IEC and advocacy.
- Opportunities for linkages with potential partners were not optimized.

with regional CHDs, the absence of strong institutional linkages in central DOH left MGP without a DOH structural or functional agency that can provide policy guidance, programmatic coherence; and serve as an advocate and champion for MGP within the central DOH.

- It can be concluded that MGP has had an impact in those barangay where the CBMIS is being implemented. Since the CBMIS is being implemented in less than 30-40% of barangay due to limitation of funds, the aggregate impact of the MGP in the 183 LGUs covered is negligible.

#### **4.3 QUANTITATIVE AND QUALITATIVE ACCOMPLISHMENTS**

In addition to the strengths and successful elements of MGP that have been cited previously, there are other qualitative and quantitative achievements that deserve to be mentioned:

- The basic training package for family planning was improved and simplified by the development of competency based training modules. Training in IUCD insertion is a case in point. Previously, providers had to perform 15 IUCD insertions in order to be certified. Under MGP, competency became the basis for certification, not number of procedures.
- CBMIS has been implemented in all MGP areas. It filled local needs for data to be used for LGU health planning. Although it only covered a small proportion of barangay in LGUs, the universal acceptance and acknowledgement by LGUs of its utility for identifying needs, targeting clients, rationalizing the work of service providers is impressive.
- MGP has surpassed its 2002 targets for enrolling LGUs, Sentrong Sigla certification, and enrollment in PhilHealth. As of January 2002, 183 LGUs had been enrolled (target=100), 110 LGUs had at least one facility that had achieved Sentrong Sigla status (target=80), and 102 LGUs enrolled in the Indigents program of PhilHealth (target=80).
- As of January 2002, 66 of the 183 LGUs enrolled in MGP had achieved the 2002 performance targets for FIC, TTG, and vitamin A

- a. On a pilot basis, MGP demonstrated that supplying clinics with IUCD kits and training IUCD providers resulted in significant increases in IUCD acceptance. Where this strategy was piloted, the number of IUCD acceptors doubled in 12 months.
  - b. In collaboration with PopCom, MGP formed Policy Champion Teams in municipality/city clusters in each of the four regions of Mindanao to advocate for the adoption of OR tested interventions such as CBMIS and service integration to enhance the information system and service provision. Both interventions were immediately adopted and funded by the local government. PopCom regional directors, who are locally influential, played critical roles as policy champions.
- Subsequent to MGP's embracing Sentrong Sigla as an essential component of its program of support, quality of care is now recognized as an important area for improving service delivery.
  - The MGP provided a balanced mix of technical assistance, service expansion, the advantages of service integration, support for quality improvement, and provision of problem solving tools (CBMIS).
  - Best Practices in service delivery and other aspects of the program were documented and shared with other LGUs

#### **4.4 PROGRAMMATIC ISSUES**

The assessment identified programmatic issues that will affect subsequent project design. The most critical issues are presented below:

- How do you target resources for greatest impact? MGP targeted LGUs based upon the CPR in the regions. It planned to expand in the 5 regions with the lowest CPR first. When asked the same question, respondents in the RFA and the regional consultative workshops felt that the best ways to target resources for greater impact were:
  - a. Based upon current performance levels
  - b. LGUs with highest population densities

because they feel that they add unnecessary bureaucratic inertia without making any positive contribution.

- Should assistance to LGUs use a project or program mode of assistance? LPP used program assistance. MGP used project assistance. In the case of MGP, project assistance was cumbersome and led to delays in fund disbursement and low expenditure rates.
- Lack of resources was the most common reason given by LGUs for poor performance of the family planning program. This finding is substantiated by data indicating that, especially in the case of lower class municipalities, the IRA is not sufficient to cover the cost of devolved services. What is the most efficient strategy for LGUs to obtain sustained increases in financial resources for family planning?
- LGUs were quite receptive to the idea of charging fees for services in their health facilities. Is this a program option worth further exploration?
- The assessment encountered a variety of inhibitory policies regarding contraceptive service delivery being practiced in LGUs. Some examples: minimum age and parity requirements for bilateral tubal ligation, new acceptors of low dose oral pills must return to the clinic monthly for resupply to monitor side effects, some LGUs do not allow community based distribution of contraceptives through BHWs, young unmarried women are not given contraceptives unless referred through STI clinics. How can standardized policies be disseminated to LGUs to eliminate inhibitory policies?
- How can IEC and counseling be improved at the local level to counteract the “fear of side effects” that discourages new users or causes discontinuation?
- How can local advocacy with LCEs and political leaders be strengthened to obtain greater political and programmatic commitment for family planning at the LGU level?
- CBMIS was very successful when introduced on a limited basis. How can it be sustained if implemented on a wider scale?

program is expanded, will other measure be necessary to guarantee sustainability?

- At this time, Sentrong Sigla certification is based on input and process improvements. It does not include outcome indicators. By including only input and process measures, Sentrong Sigla channels resources toward capital expenditures for facilities and equipment, especially when accompanied by a P1,000,000 prize. How can outcome measures be incorporated into the Sentrong Sigla certification to assess real quality of care improvements?
- A common complaint from LGUs is that demand for voluntary surgical contraception exceeds supply. How can supply be increased, and/or referral systems improved to link existing supply with demand?
- Can better linkages be created with NGOs and private providers to segment the market so that persons who can afford to pay can be referred to private providers? This would reduce pressure on the LGUs and allow LGU health services to provide free care to persons who are unable to otherwise pay.
- Can service delivery projects implemented by USAID cooperating agencies, in this case Engender Health, Well-Family Midwife Clinics, and FriendlyCare be synchronized with the LGU family planning and health program to take advantage of synergies and maximize service availability at the LGU level?

#### **4.5 LESSONS LEARNED**

The following lessons learned were culled from the RFA data, and refer to both the assessment of MGP and the delivery of family planning and health services in LGUs:

- Service providers at the barangay level (rural health midwives, barangay health workers) play a critical role in the advocacy and delivery of FP and other health services. BHWs are key to the successful identification of



ratio is between 1:25 and 1:50. More important, there is need for more investments in competency-based training as well as incentives for BHWs. There should also be mechanisms to empower the BHWs in order to maximize their performance. The CBMIS is one such tool.

- The introduction of the CBMIS contributes significantly to program success. The CBMIS is a simple tool that is attractive to program managers and much preferred over the DOH's FHSIS. Several of the LGUs visited had installed the CBMIS into every barangay. The CBMIS is consistently referred to as a most useful tool to identify unmet need for family planning services.
- The MGP operated in a very small geographic area and could not create national impact. Given that there are nearly 1,600 LGUs in the Philippines and the MGP is active in 183, there is no way that MGP, as currently constituted, can achieve national impact on contraceptive prevalence.
- To achieve demonstrable improvements in family planning and health at the LGU level, more resources are needed, both from the LGU and from "other sources." Resource limitations are the first and most common reason cited as impeding access to services and service expansion.
- MGP was most successful where commitment to family planning was highest and where the LCEs understood the link between population growth and economic development. Developing this understanding should precede any new program assistance. Fostering political commitment to family planning needs to be an ongoing activity in order to maximize the program's impact.
- Counseling on a one-to-one approach is currently not happening and is a critical element for any successful family planning program. Without good quality counseling, the high rate of contraceptive discontinuation and fear of side effects will remain as large barriers to the success of the family planning program.
- The integration of family planning services with other MCH care has enabled the LGU health system to address missed opportunities. With the information provided through the CBMIS and the service delivery

strengthening collaboration and coordination between LGUs and NGOs (e.g., Engender Health, Friendly Care, FPOP) in the area of family planning services.

- There is a lack of IEC and advocacy for family planning. IEC materials were generally not available and need to be provided in the vernacular for indigenous peoples and the Muslim community. Many RHU staff expressed frustration that they have nothing to send home with clients, and they have no instructional materials or training in natural family planning. As a result they focus all their attention on three main contraceptives - the pill, DMPA, and s.
- Advocacy for family planning is spotty at best, focused at the national level, and has yet to create a positive image of a well planned family. Beginning at the LCE level and down through the health services there is no visible advocacy for family planning, very little understanding among some mayors as to why family planning is an important development issue and no sense that a planned family is a happy, better off family.
- More males need to be actively engaged as positive role models and advocates for family planning. Currently the clinical services are entirely female focused. There is a real need to create male-friendly environments for discussing family planning and seeking out male role models from the community, and creating demand for contraception among men.
- Linkages with the private sector are weak and seldom used by LGUs to segment their clients. This includes services being provided under other USAID health and family planning cooperating agencies. It appeared to the team that the LGU public sector health services operated as if they were the only service providers for family planning. There is a real need to get the LGUs and private sector, both NGO and private-for-profit, to link up and create a complementary service.
- MGP counterpart funds can displace other health funds that otherwise would have been allocated to health. It appears that MGP has had only limited success in leveraging increased LGU spending on health. Steps need to be taken to review the current MOAs that are signed by the LGUs to minimize designating existing health funds as counterpart. LGUs need

2. Mid Term Assessment of IR1 of Strategy Objective #3, "Increased Public Sector Provision of Family Planning and Maternal and Child Health Services. Jack Reynolds, ET.al. June 1998
3. Mid Term Assessment of IR2 of Strategy of Objective 3: "National Systems Strengthened to promote and support Family Planning/Maternal Child Health Program". Charles Johnson, ET.al. July 1998
4. Rapid Field Appraisal on Reproductive Health in Selected LGUs, Population Council, 2001
5. LPP-Matching Grant Program Performance and Evaluation Report, April 2001. Population Council
  - a. Tacloban Case Study, Epe, Costello, Acuin, April 2001
  - b. Case Study, San Jose del Monte
  - c. Case Study, Dasmariñas
6. Results Framework Workshop: Background Documents, OPHN June 27-29, 2001
7. Report: Service Delivery Workshop, October 2001
  - a. Report: Service Delivery Workshop, October 2001 (Copy)
8. USAID/Philippines Strategy for FY 2000 - FY 2004, October 1, 1999
9. CA's/Partner Reports
10. 1998 NDHS
11. Philippines Medium Term Plan 2001, NEDA
12. Contraceptive Practice in Quirino Province, Phil. Measures DHS
13. Family Planning Service Utilization and Market Segmentation in the Philippines. Macroint. Inc. and Social Development Research Center, De La Salle University, October 2000.
14. Contraceptive Use Dynamics in the Philippines: Determinants of Contraceptive

18. AID Tech Report #4: Evaluation of AID FP Programs: Phil. Case Study, Schemeding, Kamas, MacManus, Pullum, undated
19. Integrated FP-Maternal Health Program (492-0480) DOH-USAID/Manila, April 1994
20. 2000 FP Survey, NSO, Nov. 2000
21. Rapid Field Appraisal of RH Care Needs and Available RH Services in the Phil. Costello, Miralao, Manganar, Masulit
22. Program Overview LGU MGP National Situation, May 2000
23. MGP-TAP Facilitation Notes, MSH, Undated
24. MGP-TAP, MSH, Undated
25. 2000 MCH Survey, NSO, February 2001
26. 2000 FP Survey, NSO, November 2000
27. National Demographic Survey, 1993, NSO, May 1994
28. Sectoral Rapid Field Appraisal (Health), 1997

## **ATTACHMENT 2**

### **GUIDE QUESTIONS**

The FGD activity was divided into three sessions:

#### *Session 1: Introduction FGD*

The Facilitator put forth a series of progression questions that directed the thinking of the groups towards making a decision and elicited response through dialogue with the participants. The idea is to allow people to become conscious to how their thinking can become action and produce group reflections and decisions based on all the available information. The whole process took about 20 minutes.

The FGD Guide Questions are as follows:

1. How long have you been involved in the family planning program?  
Oldest? Youngest?
2. Which aspect of the program have you been involved most? Who is the champion of family planning in your municipality?
3. How do you feel about the way the program is implemented in your municipality? Which aspect are you happiest? Which aspect are you most frustrated?
4. What do you feel about the devolution of the organizational structure in family planning service at the local level? Strongest links? Weakest links?
5. In your experience, what do you think are the strongest features of the FP Program? Weakest features? Which areas need to be strengthened? What works? What does not work?
6. If you were to redesign a program in family planning, what 2 areas would you first look into? Consider least?

then asked the participants to group all similar ideas and label the clustered ideas. The labels served as the group's answer to the question.

The four questions were:

1. What do you see as the major trends in the delivery of family planning services in the LGU?
2. What are the major accomplishments in family planning service delivery over the last five years?
3. What are the hindering factors that affect family planning service delivery in the LGU?
4. What are the facilitating factors that contribute to effective family planning service delivery in the LGU?

This session was completed in one (1) hour.

### *Session 3: Key Action Areas Workshop*

The group then held a mini-workshop to discuss among themselves the following:

- What activities or key areas need to be addressed immediately to enhance the delivery of family planning service in the LGU?

The group made a presentation at the end of the workshop. This lasted for about 40 minutes.